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**Exhausted without trust and inherent worth: A model of the suicide process based on
experiential accounts**

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Abstract

Methods and Rationale

Suicides are related to diverse demographic, socio-economical, medical and behavioural ‘risk factors’. Theoretical work in suicidology attempts to construct models that explicate the mechanisms underlying these suicides; however, models taking first person perspectives as their primary evidential bases are scarce. Drawing on interviews carried out by researchers at a UK mental health charity during 2010-2012 with people bereaved by suicide (n=25), suicidal individuals (n=14) and their ‘significant others’ (n=15), we present an explanatory model of the process of suicide derived from a Grounded Theory study.

Results

Suicide/attempt can be understood as the result of a complex interaction of three elements of experience: ‘lack of trust’, ‘lack of inherent worth’ and ‘suicidal exhaustion’. The first two may be seen as conditions from which the third emerges, but so that all the elements are related to each other reciprocally and the exhaustion and the suicidal thoughts, feelings and behaviours it gives rise to feed back into the initial conditions. Trust, understood as an aspect of experience that allows a person to accommodate uncertainty in relationships and in thinking about the future, is lacking in suicidal people, as is a self-determined sense of worth that is independent of external factors. Substituting inherent worth with self-worth gained from extrinsic factors, and trustful experiencing with strategies

of self-reliance and withdrawal, a person begins to consume mental resources at a high rate. ‘Suicidal exhaustion’ is distinguished from other types of chronic mental exhaustion in that it is experienced as non-contingent (arises from living itself) and hopeless in that the exhausted person is unable to envisage a future in which demands on his/her mental resources are fewer, and their replenishment available.

Conclusion

The model has potential applications for public participation in suicide prevention, which should be mapped and assessed in further research.

Introduction

Suicidal acts in the UK are carried out by males and females from all socio-economic groups (Williams, 2001), from both majority and minority ethnic backgrounds (Bhui et al., 2012) and at all life stages (Fincham et al., 2011). Precipitating factors for suicidal behaviour are varied, including childhood adversity, recent bereavement, relationship instability, redundancy (Cole-King & Lepping, 2010), retirement (Lewis & Sloggett, 1998), physical health problems (Bazalgette et al., 2011), substance misuse and psychiatric problems (Cavanagh et al., 2003). In mainstream suicidology epidemiological or psychological autopsy studies (Houston et al., 2001) describe this range of socio-economic, medical and behavioural factors. Yet ‘risk factors’ are never sufficient as motives for suicide: all are survived by countless individuals. They also fail to explain *how* it is that they are related to suicidal behaviour (Hjelmeland & Knizek, 2010). This study explores the process of suicide as experienced by those who have attempted suicide, their friends and family, and those who have been bereaved by suicide. In particular, it aims to understand the interplay of inter- and intrapersonal experiences in the time preceding a suicide or attempt.

Theories of Suicide

Viewing distress and suicide as intrapsychic or biological processes within discrete organisms neglects the relational context of distress and wellbeing, resulting in a narrow, diagnostically-led focus on the individual in mental health services and policies (Pilgrim et al., 2009). This view prevails in recent suicidology despite an early focus on the social: Durkheim (1897/2002) argued that too much or too little social integration (that which connects us to a social structure) or social regulation (that which provides order and structure) could account for suicide. Murray (1938) viewed suicide as the result of having important psychological needs, including achievement, nurturance, order and autonomy, thwarted or unfulfilled; like Durkheim, he suggested social affiliation was particularly important.

More recent theories, e.g. the 'escape theories of suicide', continued the focus on intrapsychic processes with an element of the social. Baumeister (1990) described suicide as the sixth step in a chain of social and psychological processes resulting in a "wish to escape from meaningful awareness of current life problems and their implications about the self" (*ibid.*, pp. 91). Persistent failures to control negative affects relating to unfavourable, self-blaming comparisons between a standard and the self or circumstances eventually lead to a suicide wish. On Schneidman's (1992) account, on the other hand, 'psychache' is the primary cause of suicide, so that the unbearable psychological pain of shame, guilt, dread, loneliness and so on, and the different individual tolerances for that pain explain suicide. Yet he too notes that social affiliation is an important human need that, if thwarted, can lead to suicide. Williams (2001) argued that both intrapersonal (e.g. 'mental illness') and interpersonal (e.g. relationship breakdown) factors can 'cause' suicide, but only insofar as the person feels s/he is unable to escape an uncontrollable stress arising from them. As with Schneidman (1993), the uncontrollability of mental turmoil is central to the explanation of suicide. In all these theories, the person is seen as having lost hope for change, echoing Beck's work connecting 'hopelessness' and suicide (Beck et al., 1990).

Humans need frequent, positively valenced interactions with others, and at least one strong, stable and reciprocal relationship characterised by care and concern (Baumeister & Leary, 1995). If deprived of either of these, individuals are more likely to be unhappy, lonely, and stressed, and risk increased

physical and mental health problems and suicide (Baumeister & Leary, 1995). Joiner's (2005; Van Orden et al., 2010) "comprehensive" (Van Orden et al., 2010, pp. 580) interpersonal-psychological theory of suicide explicitly links the social and psychological factors found to influence suicide in empirical studies through two dynamic cognitive affective states: a thwarted need for belongingness, and the perception that one is a burden to others. The concept of thwarted belongingness combines two major factors, loneliness (feeling disconnected), and the absence of reciprocal care (no one to turn to, no one to care for) made manifest through for example, childhood abuse, divorce, living alone, and domestic violence. The perception of being a burden is similarly two-dimensional: liability (death is worth more to others than life) and self-hatred.

There is a growing but still small body of qualitative research contributing to the understanding of suicide. One of the widely recognised strengths of qualitative research is that it is capable of reflecting the diversity of experiences, often in a relatively homogenous participant group to whom the research seeks to 'give voice'. Previous qualitative studies of suicide have tended to focus on elements of suicidality in specific populations, such as people with schizophrenia (Skodlar et al., 2008), young and middle-aged men (Jordan et al, 2012), older adults (Crocker et al., 2006; Bonnewyn et al., 2014), male prisoners (Rivlin et al., 2013), or LGBT (McDermott et al., 2008). A smaller number of studies have included the perspectives of both people who have attempted suicide and those caring for them (Sun et al, 2009). While this work contributes to our understanding of suicide, for the most part it aims at exploring risk and preventative factors for suicide (Rivlin et al., 2011; Sweeney et al., 2015), and understanding help-seeking behavior and support for people who are suicidal or those who care for them (Jordan et al, 2012; Sun et al., 2009). While some valuable insight is offered into the affective and interpersonal experience of suicide, for example the role of the family in maintaining a feeling of connectedness (Sun et al., 2009), a more extensive exploration focused on the development of a theory of the process of suicide from the perspectives of those who are suicidal and the people who are close to them at the time of their suicide or suicide attempt is needed. As far as we are aware this is the first study attempting to create a comprehensive theory (Van Orden et al., 2010) of the suicidal process from such an exploration.

Method

Study Design

This research aimed to explore the lived experiences of the process of suicide from the perspectives of people who had attempted suicide, their ‘significant others’, and people bereaved by suicide. The study utilised grounded theory method (GTM), to move beyond the descriptive to a more abstract, explanatory level, in this case to develop an explanation of suicidal behaviour based on descriptions of the lived experiences of the process of suicide. GTM (Glaser & Strauss 1967), is a “family of methods” (Bryant & Charmaz, 2007; pp. 11) used by researchers from diverse disciplinary and theoretical backgrounds (Charmaz, 1990). A central tenet of GTM is that the analytic representation (the model) must not be forced on the data, but should emerge from them (Glaser & Strauss, 1967).

Participants

Participants were self-selecting and recruited through a UK mental health charity, leaflets at a Coroner’s office and via calls in the media. Inclusion criteria required that participants had made a suicide attempt, were a significant other of this person, or someone bereaved by suicide. The suicide/attempt must have occurred less than six years previously, but at least 12 months ago. Fifty-four people participated in the study, including 14 who had attempted suicide and 15 of their significant others, plus 25 people bereaved by suicide. ‘Significant others’ were mostly partners/spouses ($n=5$) or friends ($n=4$). In the bereaved group, just over half ($n=14$) were bereaved parents (11 were bereaved mothers). Of the 21 cases of completed suicide discussed, 62% were by men ($n=13$). Most of the attempted suicides were by women ($n=11$; 79%). The people who completed suicide were 21-63 years of age at the time of death ($mean=39.71$; $sd=12.31$); the people who had attempted were 19-55 years of age ($mean=40.00$; $sd=11.96$) at the time of participation. The majority of cases of suicidal behaviour were by people identified as White British (79% of people who had attempted; 86% of people who had completed).

Ethics

Ethical approval was obtained from East London & The City Research Ethics Committee Alpha (UK National Health Services; study reference number 10/H0704/17). All participants gave their ongoing, informed consent to participate. Participant care was always the priority and it was incumbent on the researcher to stay emotionally present during data collection and to respond appropriately to participant distress. Researching suicide raises particular ethical issues and requires skilled and sensitive researchers (Gibson et al., 2014). Follow-up calls/emails were made a few days after participation and each participant worked with a dedicated researcher, who guided them to support as needed.

Data Collection

The data were collected in United Kingdom between 2010 and 2012. Semi-structured interviews were conducted, lasting between 1 and 6 hours (including breaks). The length of the interview was guided by participants. All interviews began with an open question: “Can you tell me about [name of the deceased] and how s/he came to kill him/herself” or “Can you tell me about how you came to attempt suicide?” After the narrative came to a natural conclusion, the researcher used a topic guide to elicit more detail, focusing on participants’ experiences of body-self (e.g. their embodied experience prior to the attempt; how the person appeared prior to their suicide), relational experience (e.g. interactions, relationship quality), and their experience of the world (e.g. how they perceived their environment and those around them). Of the 46 interviews 41 were face-to-face, 3 were conducted by telephone and 2 by email. The email/telephone interviews were offered as a choice to enable participation of those who did not wish to be interviewed face-to-face. All but 3 people who had attempted suicide were interviewed together with their ‘significant other’ (the 3 preferred separate interviews). Interviews were transcribed verbatim; with participants given the opportunity to review transcripts.

Data Analysis

Data analysis began immediately after the first interview. Analysis then informed further data collection in iterative cycles. Analysis was inductive, with no predefined coding scheme (Glaser & Strauss, 1967). ‘Incidents’ in the interview data (meaningful units such as a significant other

describing an attribute of the deceased) were assigned tentative categories, often an ‘in vivo’ code such as ‘didn’t trust anyone to do anything for him’ (Charmaz, 2006). As analysis progressed, coded incidents were constantly compared with one another and with new incidents, until relational properties between the initial categories started to emerge and could be grouped together to form subcategories (e.g. ‘self-reliance’) and ultimately, the main categories or explanatory model. MaxQDA-10 was used to manage and sort data.

All authors were involved in data collection and analysis. Regular consensus meetings to compare case notes and analytic memos were a crucial part of the analysis, during which we experimented with category titles, discussed opposites, debated the fit and extension of concepts, and challenged each other’s interpretations (Wiener, 2007). The first articulation of the model was developed with reference to literature from a wide variety of disciplines, including psychology, sociology and philosophy. The final model is intended as a valid representation of the lived experiences of the participants and a theory of suicide in terms of relational affective experiences causally relevant to suicide. The model was validated with some of the participants and a wide range of other stakeholders.

Results

In the following sections we define the categories and, using illustrative examples, describe the incidents that gave rise to them.

Lack of Inherent Worth

[Figure 1 about here]

I absolutely hate myself, I can’t even express, the word hate is not even enough, it’s more than that and that side of me just has completely no self-worth and that side would just take over. (Female, 24, attempted suicide)

She wasn't content with herself, unless she was giving. And that is an excellent trait to have until you take it to the extreme of not being (...) satisfied with yourself, and she wasn't towards the end (Male, 65, wife died by suicide at 55)

What is of worth is both meaningful and has value. People whose experience is one of inherent worth find themselves and their social world meaningful and valuable in a way that is non-contingent and enduring. Experiences of inherent worth are strongly action-guiding: people do things because they appear worthwhile, without needing further justification. By contrast, the experience of a lack of inherent worth is the sense that what is of worth is unreliable or contingent. The value of the person and the meaning – or “point” - of anything in their life is experienced as derivative of and dependent on something else.

Lack of inherent worth could be observed in the data in two principal forms: as experiences, and as consequences for the person's choices, attitudes and interpretations of self and situations. Some participants described a vulnerability to negative thoughts and feelings about the self, and a tendency to self-blame (or in some cases blame others as a defence). Feelings of worthlessness and self-loathing could emerge rapidly, for example in response to status changes or perceived negativity from others. The person was likely to blame him/herself for any difficulties experienced, often feeling undeserving of and unwilling to engage with help. Typically other people's needs were placed ahead of their own.

Additionally, when nothing appears meaningful or valuable, events, other people and environments elicit no emotional response. Aware of the loss, the person may continue to act as usual, but effortfully, without spontaneity. Suicidal participants reported being “numb” to the world and in particular, unable to experience joy, but they were able to hide this from others by behaving normally or especially exuberantly. However, as the suicide/attempt drew nearer, some significant others detected this lack of responsiveness, describing the suicidal person as “zombie-like” and “not really there”.

Participants also described what can be understood as strategies of substitution: ways of behaving and interpreting situations, which create value and meaning in lieu of 'inherent worth'. These strategies (though part of ordinary human life) were problematic because they functioned to substitute rather than to generate or express inherent worth.

For some participants this took the form of over commitment to or dependence on a role, goal or project. A 'role' can be created around a profession ('doctor') or around family life ('mother'), but it can also be a less well-defined idea of 'the person one is meant to be', a socially constructed sense of who one is that is usually quite strongly determined by the needs or expectations of others. Roles, goals and projects bring meaning and value to any life, but when inherent worth is absent they can become the sole source of worth. This leaves the person vulnerable following, for example, perceived failures at work, unemployment or children leaving home. When such a crisis happens the person not only ceases to value themselves; they no longer know what to do in a very concrete sense of 'how to fill one's days'.

Self-sacrifice and reconstructing self-worth as utility to others were also used as strategies for creating self-worth and purpose. Almost by definition these implied the suppression or neglect of the person's own feelings and needs. Some, for whom the love of particular others came to define them and their sense of worth, experienced the perceived anger or withdrawal of the loved one as extremely threatening.

Lack of Trust

[Figure 2 about here]

It was only five or ten minutes that I was waiting for my husband and daughter to pick me up, but I kept on thinking: 'They're not coming back for me, this is their way of getting rid of me and getting my house'. (Female, 48, attempted suicide)

I think he had a lot of trust issues from his divorce. We tried to encourage him to take partners [at work] so he could occasionally have a holiday, but he wouldn't trust anyone.

(...) 'Right, I'm going to do it myself from now on'. That was the kind of attitude he had to most things, he didn't really trust anyone to do anything. (Male, 28, father died by suicide at 59)

Trust allows people to manage uncertainty in their knowledge of self, others, and the future, to tolerate not fully knowing what other people think and feel, and being unable to predict, or fully understand the reasons behind, what others do. Trusting another also involves a general attitude of goodwill about the trusted person and their competence, and a readiness to interpret their actions favourably. Trust enables people to act on the basis of their implicit understanding of self and others regardless of the incompleteness of their knowledge. Lack of trust, on the other hand, makes uncertainty intolerable, inhibits agency and creates social distance.

As with 'lack of inherent worth', incidents of lack of trust appeared in the data both as experiences of this lack, and as consequences of it, as compensatory changes in the way the self is construed and enacted in relation to others. Lack of trust was manifested as overwhelming feelings of anxiety or outright fear, unrelenting doubts and worries and social phobias. The anxiety experienced could be so severe that it led to an inability to undertake any meaningful activity. A sense of interpersonal distance was both a part of experiences of mistrust and a more enduring feature of participants' relationship with the social world. They felt that something was missing from relationships with other people, and this lack of connection was also experienced by significant others as the suicide/attempt drew nearer. In some cases, lack of trust had a more confrontational presentation, manifesting as distrust, paranoia and anger; relationships were marked with a sense that there was some kind of deceit in the relationships or others were hostile and uncaring.

Mistrust/distrust could also mark the relationship with the self, and this often arose directly from suicidality. Suicidal feelings, thoughts and actions brought with them a sense of the self as untrustworthy, both in the eyes of others and of oneself. Some lives that ended in suicide were marked by low self-confidence manifesting as a long-standing struggle with trusting oneself to rise up to

challenges and manage responsibilities. However, it was more often the case that loss of self-confidence, agency and the ability to take on responsibilities occurred as an integral part of the process of suicide, at a relatively late stage and together with a lost sense of self-control.

Like inherent worth, trust is necessary for living well and when absent, people can seek substitutes. Two strategies were used: self-reliance and dependence. Both can be positive but when used as substitutes for a lack of trust, create a fragile defence against severe mental distress. Sometimes the strategies were used alongside each other; sometimes strategies of dependence were adopted after self-reliance had failed.

Emotional self-reliance in this context implies hiding negative feelings and thoughts to protect oneself or others and in some cases emotional regulation by self-harm and/or substance abuse. Practical self-reliance involves a preference for independent working and living, a tendency for taking charge of situations or controlling others or resistance to sharing responsibilities or workload. These practical strategies succeed in creating temporary certainty, control and order but are unsustainable. Since self-reliance requires the person to trust themselves and their abilities, when competence seems diminished, the substitution strategies can be characterised as emotional or practical dependence (which can be experienced very negatively) or seeking external validation. Dependent relationships could not replace relationships of trust however, not only because they lacked reciprocity but because the suicidal person continued to seek certainty, for example through demanding constant (and unsustainable) physical presence or emotional availability from the other.

Suicidal Exhaustion

[Figure 3 about here]

Throughout all my depression I've always been able to be okay for other people. But I couldn't do it any more, I just couldn't. And they kept saying to me, what is it, what is it? I'm going: "I'm just so tired." That's all I kept saying, "I'm so tired". Forages. And they were going: "But why?" And I couldn't explain what that meant, I just knew that I was so tired.

And I wanted peace, I wanted some peace. And [suicide] was the only way. (Female, 44, attempted suicide)

He needed to go to sleep (...) He used to say, "I just want to turn the switch off." (...) He'd try with every bit of energy to keep busy. You know, [in] the earlier days of not sleeping he would be able to do that, [thinking] 'if you keep busy, you get exhausted, you go to sleep'. But (...) then his eyes would go into big eyed open mode... he couldn't turn it off. And he would definitely become more and more suicidal then. (Female, 51, son died by suicide at 31)

Suicidal exhaustion is a chronic mental exhaustion that is both a condition experienced by people and/or a process of gradual depletion of 'mental resources'. It differs from ordinary chronic mental exhaustion, firstly because it arises from living itself, rather than from some contingent part of life, and is therefore conceptually distinct from, for example, work-related burnout. Secondly, it involves hopelessness: the exhausted person is unable to envisage a future with fewer demands on his/her mental resources, and has lost trust in his/her ability to rest.

Some participants focused on feelings, reporting a special sense of tiredness or exhaustion that was extraordinary in some way that was difficult to describe. Though a 'mental exhaustion', the experience has a bodily phenomenology: the body can feel leaden and heavy, or weak. Other participants focused on performance, describing a sense of effort and difficulty attached to routine or previously effortless tasks, or a drop in mental ability. An experience described as 'loss of motivation' implied having to make a mental effort where one was not previously required, and a simultaneous increase in perceived task difficulty. 'Inability to concentrate', 'lack of mental strength' and 'intellectual exhaustion' were among the expressions characterising this experience of depleted mental powers. In the few weeks immediately preceding a suicide/attempt, performance could collapse and the person fall into either unfocused restlessness or passive inactivity.

The non-contingency of the exhaustion and the hopelessness that can accompany it are important.

Suicidal exhaustion can be experienced as the condition in which suicide is the only way to stop the

relentless demand on mental resources and to rest. Living comes to be seen as incompatible with restfulness.

Suicidal Exhaustion, Lack of Inherent Worth and Lack of Trust

Suicidal exhaustion is best understood in the context of the other two categories, ‘lack of inherent worth’ and ‘lack of trust’. Living without inherent worth often implies over-commitment to roles or goals and having very high standards of performance. It may also mean that the person has a sense that they need to do something more and better than is required of others in order to be of value. This – be it academic excellence or altruistic pursuits, or something else – is then pursued without due attention to the conservation of mental resources and regardless of mental or physical ill health.

Negative, including suicidal, feelings and thoughts are hidden from others, suppressed and denied.

This arises from lack of trust and lack of inherent worth insofar as feelings, thoughts and behaviours are hidden or suppressed because they are inconsistent with role performance. The strategies used to substitute for inherent worth and trust therefore place a heavy demand on mental resources.

Suppression of difficult feelings and thoughts while creating worth and managing uncertainty by ‘performing a self’ requires constant effort. Strategies of self-reliance prevent sharing burdens until exhaustion forces a switch to a dependent way of coping. By then the exhaustion is severe, but the continued need to defend against loss of worth and manage anxiety can mean oscillation between high and low functioning. Significant others reported abrupt switching between what to them seemed almost like two people.

Sleep disorder, anxious ruminations and uncontrollable thoughts are also highly relevant to the process of suicidal exhaustion. People were often not sleeping, or having poor quality sleep, no better than “just lying there with your eyes closed” (Female, 24, attempted suicide). Some experienced vivid nightmares; others woke in a full state of anxiety, un-refreshed. Suicidal exhaustion offers both a motivation for suicide as the primal need to ‘switch off’ and a justification for it, as the self becomes experienced as useless, ‘just a burden’ to others.

The Model

[Figure 4 about here]

The process of suicide is a complex interaction of three elements of experience: ‘lack of trust’, ‘lack of inherent worth’ and ‘suicidal exhaustion’ (see Figure 4). The first two are conditions in which the third emerges; however the relationships between all three elements are reciprocal. The Figure 1 arrows indicate the dynamic way in which the experiences unfold together. ‘Lack of trust’ and ‘lack of inherent worth’ precede ‘suicidal exhaustion’: many, if not the majority, of participants lived for years trying to substitute for trust and inherent worth before they became suicidally exhausted. Even in cases where the suicide/attempt seemed sudden, narratives contained references to pre-existing problems with trust and inherent worth. ‘Lack of inherent worth’ and ‘lack of trust’ are interlinked through codes such as ‘lack confidence’ (the inability to trust oneself to make a valuable contribution) and ‘lack of reciprocity’ (the absence of a key ingredient of a trust relationship, which indicates either that the suicidal person feels unworthy of care (self-reliant strategies) or unable to respond to the needs of others (dependent strategies)).

In addition there were developmental narratives in which a variety of problematic family relationships seemed to impact the ability to trust others and the person’s self-worth, and prevent safe exploration and interpretation of feelings and interests from which inherent worth could develop. The Figure 4 returning arrows indicate that suicidal exhaustion degrades a person’s sense of inherent worth, self-trust and trusting relationships. Participants’ repeated suicide attempts meant that the suicidal person and family members no longer trusted themselves or each other to manage the situation, and the suicidal person’s perception of being ‘just a burden to others’ gained strength as suicidal feelings and behaviours became more established.

Discussion

The present study explores in detail the processes by which a person becomes suicidal and attempts or completes suicide. Two processes, an increasing lack of trust and lack of inherent worth, lead to and feed into, a third process – suicidal exhaustion. This model explains the suicidal process.

Lack of Inherent Worth as Effortful

The model distinguishes between inherent and contingent worth. Our data support the idea that ‘self-hatred’ alongside low self-esteem and self-blame are parts of the suicidal process (Van Orden et al., 2010); in our model however they are expressions of low ‘inherent worth’ of which, following exhaustion, feelings of burdensomeness are a consequence.

Among the cases of suicide and suicide attempt were both people who were high achievers and seemingly confident, and those less accomplished or sure of themselves, yet they shared a sense of worth contingent on external structures (job, caring role, etc.). When through circumstance, these no longer provided stable and substantial sources of worth, they became vulnerable to suicide.

Deci and Ryan (2000) argue that, more than failures and successes, it is how the individual relates to the content of their goals and their reasons for pursuing them that are associated with differences in mental health. Self-determined pursuits (motivated intrinsically or by well-internalised external motives rather than extrinsically by rewards, external evaluation or avoidance of punishment or shame) and intrinsically meaningful and worthwhile goals (rather than goals reliant on contingent approval or external signs of worth) result in wellbeing. Achieving goals of extrinsic worth requires “internal prods and pressures” and is “characterised by inner conflict” between the demand of the extrinsically motivating factor and “the person’s lack of desire to carry it out” (pp. 237). Our model suggests suicidal process is founded on goal-oriented and value-led behaviour carried out in pursuit of contingent self-worth as a substitute for inherent worth. Contingent self-worth depends on successfully fulfilling the requirements of a role, a goal - or any self-interpretation (a set of values) for that matter. If the person also sees these (and herself) as inherently meaningful and valuable, their pursuit is driven not merely by beliefs about what one ought to do, but by situation appropriate affective responses. These are absent when inherent worth is diminished. The finding is consonant with the results of our previous study, in which we showed how the experience of suicidal feelings is often a deep-reaching conflict between goals and values on the one hand, and emotional responses on the other. Agency is disrupted and depleted, and the person fails to function as an integrated self (Benson et al., 2013). Such incongruence is experienced by suicidal people as effortful, and is cognitively expensive (Baumeister et al., 1998). By contrast, self-determined motivation has been

found helpful in maintaining behaviours (Deci & Ryan, 2000), particularly when greater effort or persistence is required to carry out a socially-valued action (Green-Demers et al., 1997).

Baumeister (1990) argues that a narrowing of time perspective, the absence (or “irrationality”; pp. 104) of plans, concrete rather than abstract thinking, and the “rejection of meaning” (pp. 101) form a ‘strategy of cognitive deconstruction’ used to achieve an emotionally numb state in the face of distressing self-appraisals. Arguably, this is not a strategy at all, but a consequence of exhaustion, which can be partially attributed to a pre-existing state of meaningless, numb inertia. This interpretation is consistent with the reported experiences of our suicidal participants, who characterised this state as a failure of mental ability (a further threat to self-worth). Escape from this state was for many a part of the ultimate motive for suicide.

Trust, Anxiety and Mental Resources

To trust is to “behave ‘as if’ we knew the future” (Sztompka, 1999), circumventing the need to calculate all possible outcomes. Such calculations are cognitively expensive and incapable of producing certainty: the harder one has to work at arriving at a proposition the less certain one will be of its truth (Schwartz et al., 1991). Anxious ruminations may be understood as a pursuit for certainty (Nolen-Hoeksema, 2000), whereas trust is “a mechanism that allows people to cope with uncertainty” (Lahno, 2001, p187). Anxiety disorders (Sareen, 2011), symptoms (Busch et al., 2003) and trait anxiety (Brezo et al., 2008) have all been linked with suicidal behaviour.

Lack of trust and lack of inherent worth interact in the experience of anxiety. When overwhelmed by anxiety, nothing seems more worth doing than anything else. The kind of practical significance that characterises experiences of inherent worth ‘falls away’ in anxiety (Heidegger, 1962/1927) and the world appears inaccessible to the person. There is a felt sense of weakness (Mumford, 1994) and, in lieu of a trustful commitment to things turning out well, a mental life preoccupied by processing too many, undifferentiated possibilities. Combined, this amounts to a sense of exhaustion and fearful loss of trust in the person’s capacity to withstand the demands of the situation.

Trust is also inherently relational. Løgstrup (1956, p18) emphasises the fundamental *necessity* of trust for living. Trust helps people bond, integrate meaningfully into a community, and gain ‘social capital’ (Kawachi et al., 1997). It allows individuals to have a stake in their community and to play a part in collective structures. Simpson (2012) argues that trust is a response to the basic features of what it means to live socially – reliance, cooperation and anxiety. Social relationships are intrinsically anxiety provoking, as others are unknown, unpredictable and beyond our control; therefore trust is indispensable for living (Sztompka, 1999). ‘Lack of trust’ seems consonant with the thwarted need for belongingness described in Joiner’s interpersonal theory (Van Orden et al., 2010), and may represent the mechanism through which it comes about. When we do not, or cannot trust, the possibilities available to us relationally begin to diminish (Løgstrup, 1956). The more we mistrust (or experience ourselves as untrustworthy), the more isolated or alienated we become, and the more thwarted our need to belong. Trust also involves an assumption that a relationship is built on competence, and motives are imbued with care and concern (Govier, 1993). Mistrust can enter into the relationships of suicidal people through the suicidal person’s perception that the other is unable to tolerate difficult feelings and respond appropriately, and through the other’s perception that suicidal thoughts or acts call into question the competence and caring motives of the suicidal person.

A lack of trust prompted individuals to find substitutes such as self-reliance to help them function as social agents. Self-reliant agency excludes others at the expense of the kind of practical and emotional connectedness that comes from involving others in one’s projects, sharing personal goals and disclosing thoughts and feelings. Consequently, when problems inevitably occur, these are faced alone, and the regulation of stress and negative emotions is wholly intrapersonal.

Potential Psychological Processes Contributing to Suicidal Exhaustion

To the extent that the cognitively expensive substitution strategies for inherent worth and trust fail to work, overwhelming feelings of anxiety, shame, guilt, self-loathing, helplessness, hopelessness, worthlessness or anger (Schneidman’s (1993) ‘psychache’) result in a resource consuming need to self-regulate. According to Baumeister’s ‘Ego-depletion hypothesis’ emotion regulation uses the same

resource as the kinds of decision-making and direction of thought and attention involved in substituting for inherent worth and trust (Baumeister et al., 1998), and it therefore contributes to any exhaustion already present. Emotional pain becomes intolerable when the resources for self-regulation are sufficiently diminished, and respite through sleep or positive affect becomes impossible. The suicidal desire to ‘escape from psychache’ is actually also a desire *for* rest; Schneidman (1966) himself noted a connection between death and sleep in reasons people give for suicidal acts.

The experiences of extreme tiredness, effort, and the felt inability to respond to challenges requiring attention and concentration, which were evident in our data, appear to indicate mental exhaustion. Experiences of effort provide information about task difficulty relative to resources and may indicate progressive exhaustion, so that the more depleted the resource the more effortful the action (Bayne & Levy, 2006). However, experiments show that if people believe that self-control depends on an unlimited resource they fail to exhibit ego-depletion effects (Job et al., 2010). Beliefs about future ability to respond to mental challenges therefore have a bearing on how much energy someone is willing to expend in the present. If the *experiences* of effort and exhaustion track this process, then the experiences will have, as Bayne & Levy (2006) suggest, a teleo-anticipatory character. This may be important for understanding how a state of mental exhaustion becomes suicidality.

As noted, hopelessness is an important contributor to suicide in virtually all recent theories of suicidal behaviour. In our model, hopelessness distinguishes suicidal exhaustion from other forms of chronic mental exhaustion. Studies have shown that suicidal people are less able to imagine a positive future, and that their future-directed thinking is vague, infrequent and presents a truncated future (Williams, 2001). Consequently, they are unable to sense how much demand the future will place on their mental resources; if they do strive to imagine a future it will be populated with resource-depleting factors, such as sleepless nights and negatively-valenced events. Insofar as experiences of exhaustion are teleo-anticipatory, hopelessness deepens them.

However, unlike many other theories, our model does not rely on the idea that hopelessness is sufficient for seeing *suicide* as the only escape from stress. With inherent worth gone or diminished,

meaning and value have to be generated via extrinsic goals and pursuits, and this cannot happen effortlessly but requires self-regulation. The cognitive deficits that spell trouble for future-oriented thinking are particularly potent for people who, lacking trust, seek certainty. With trust, the person would perhaps launch themselves into the future and relationships without knowing the outcomes; without trust, they are forced to choose between anxiety and strategies that are cognitively expensive (e.g. self-reliant coping, rumination). As such, living implies effort and suicide beckons as rest.

Limitations

The majority of participants were White British, and therefore the model's application to understanding *all* experiences of suicidality may be limited. In addition, all suicidal people in the study were working age adults; again limiting the scope of the model and indicating further research is required. It has been noted that people who volunteer for a psychological autopsy study tend to be those from a more stable social background than is typical of suicides overall (Appleby et al., 1999), however, our sample included people from a range of backgrounds, allowing confidence that the same concerns with trust, worth and exhaustion arise regardless of socio-economic status. It should also be noted that although most suicides are completed by people not in touch with specialist mental health services, just over 70% of the suicidal people in the present study had accessed the services within a year of the suicide/attempt.

Conclusion

Understanding the process of suicide in terms of experiences – of lack of trust, lack of inherent worth and suicidal exhaustion - offers a novel way to think about the meaning of the events, illnesses and behaviours that precipitate suicide. As such, it could arguably be used to support lay efforts in suicide prevention, insofar it helps 'significant others' of suicidal people to interpret their own experiences and respond to the suicidal individual appropriately in his/her unique situation. Future research should map potential applications for this model in suicide prevention and assess its usefulness in real life suicide prevention scenarios. Any significant differences between gender and age groups should be described and the model modified as necessary. .

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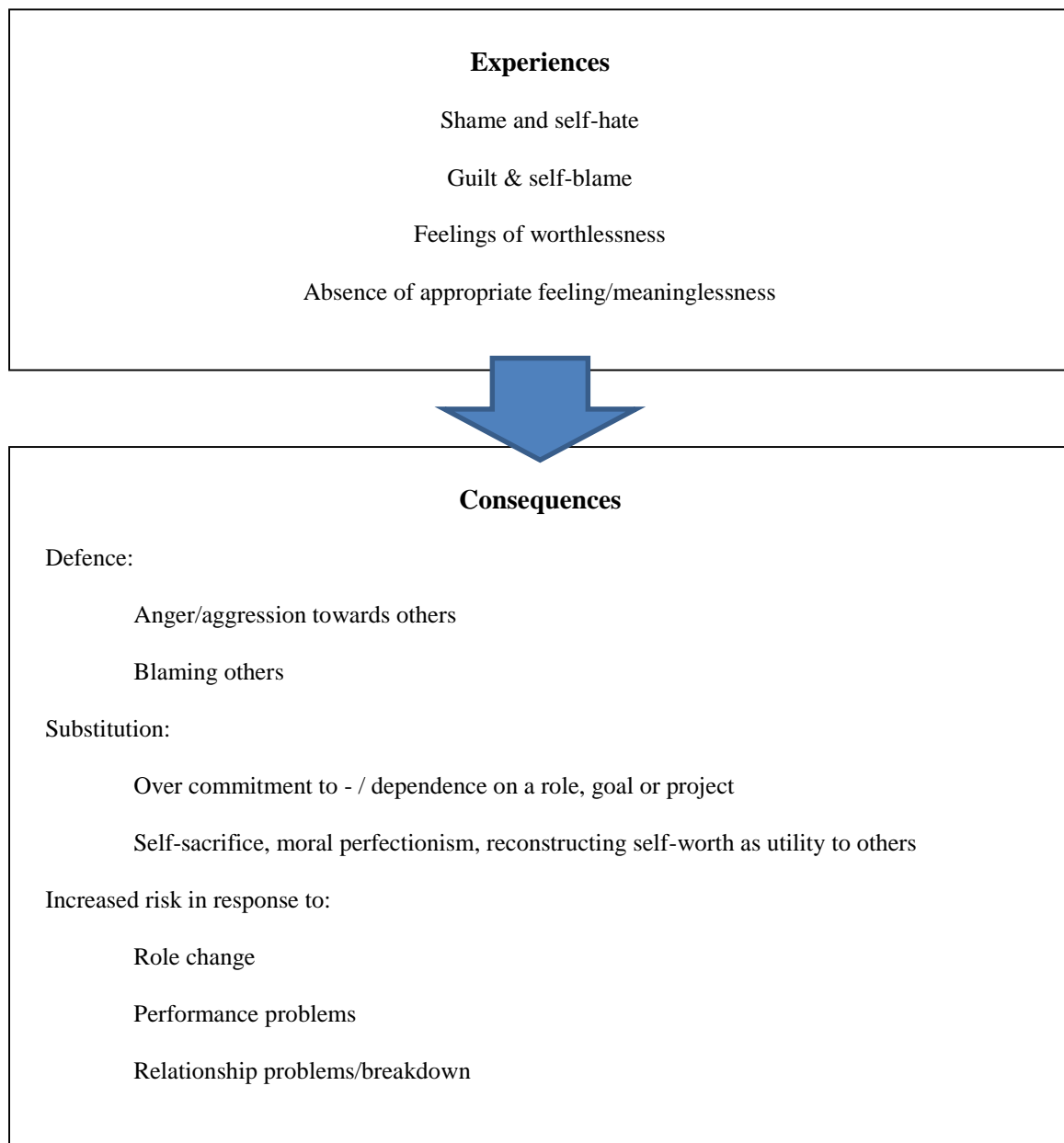


Figure 1. Lack of Inherent Worth

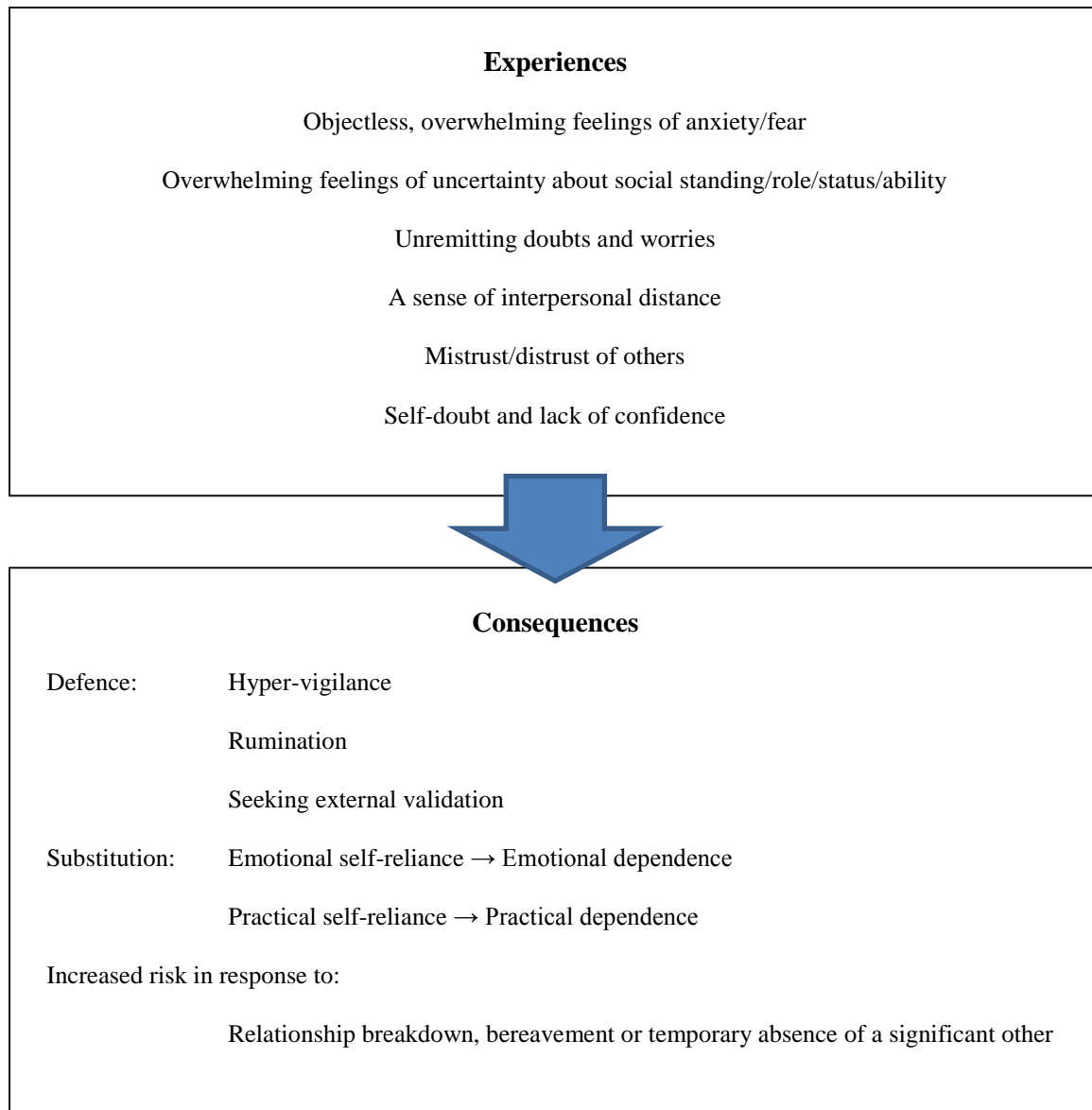


Figure 2. Lack of Trust

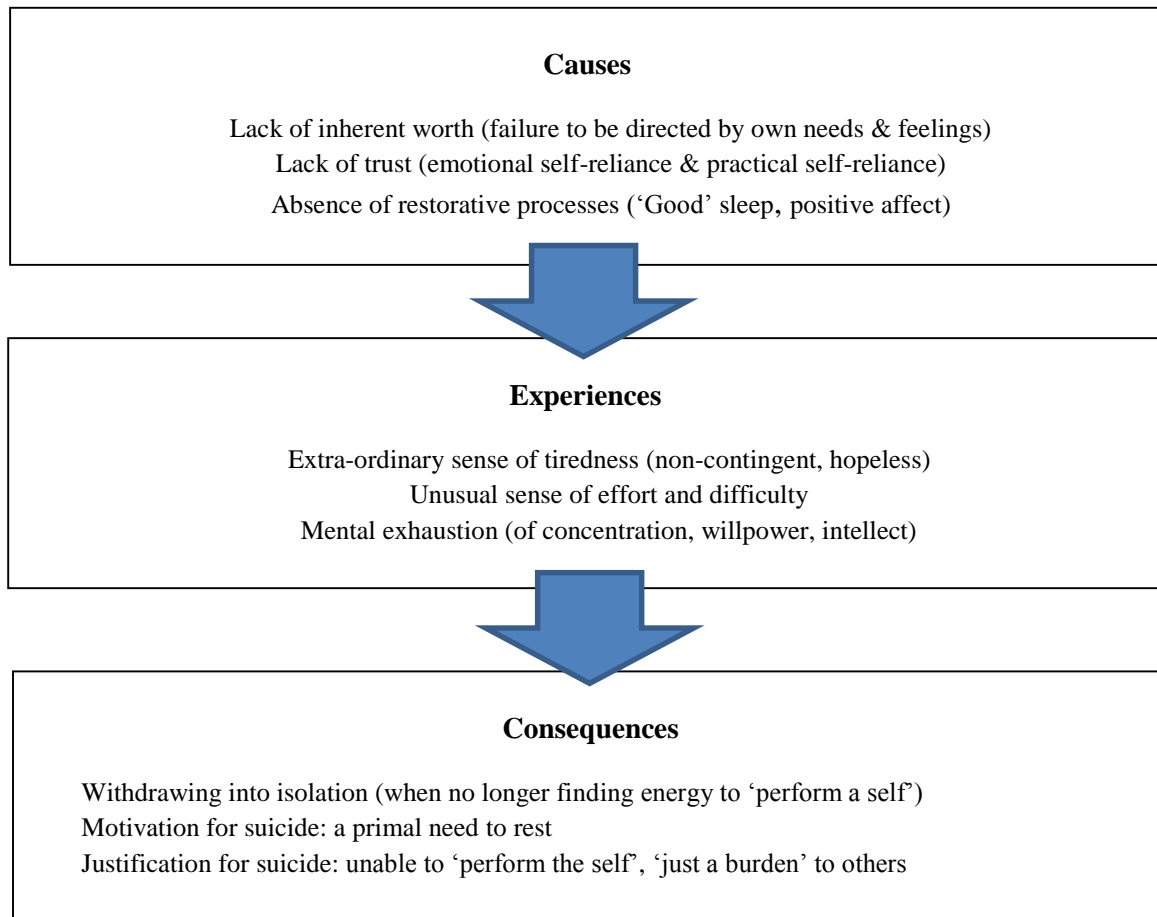


Figure 3. Suicidal Exhaustion

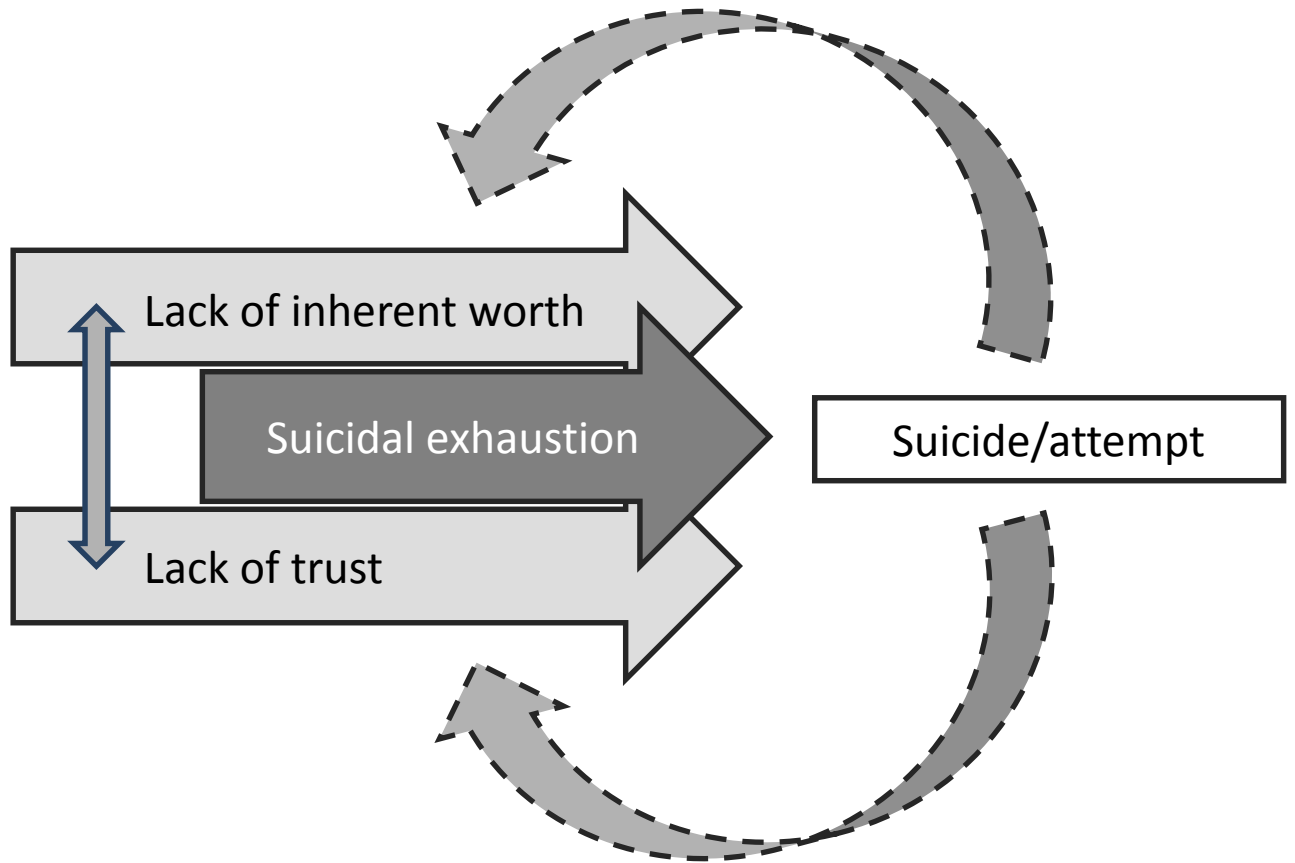


Figure 4. The Suicidal Process in Terms of Relational Affective Experiences